

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14190

14185

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Norman Frederick Quackenbush</i>		First <i>Norman</i> Middle <i>Frederick</i> Last <i>Quackenbush</i>	4. DATE OF DEATH <i>October 31 1967</i>			
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5-26-1884</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>			
13. FATHER'S NAME <i>William Allen Quackenbush</i>		14. MOTHER'S MAIDEN NAME <i>Not Available</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577 10 9072</i>	17. INFORMANT <i>Ed. Curtis Quackenbush</i>			
		Address <i>802 Jackson Ave T.P.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary of lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>				
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>lost.</i>		(b) <i></i>				
		(c) <i></i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>1958</i>	(County) <i>to 10-31</i>	(State) <i>1967</i>
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>10-31</i> , 1967, that (I) (we) last saw the deceased alive on <i>10-31-1968</i> , and that death occurred at <i>6 P.M.</i> from causes and on the date stated above.						
22a. SIGNATURE <i>James W. Willock</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>10-31-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>JAMES WILLOCK</i>		22d. ADDRESS <i>777 Carrollton Takoma Park Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 3, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Haven Cemetery</i>	23d. LOCATION (City or Town) <i>Calverton Prince George's Co</i>	(County) <i>Calverton</i>	(State) <i>Md</i>
24. FUNERAL DIRECTOR <i>J. Arthur Weller</i>		ADDRESS <i>254 Carrollton NW DC</i>		25a. REC'D BY REGISTRAR <i>NOV 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

FOR STATE  
HEALTH DEPT.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

ITEM #9 F 11M #G393 10/13/07 P

**MEDICAL EXAMINER'S CERTIFICATE**

Item #15 Film #G393 10/18/67 p

14191

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>17 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		b. COUNTY <b>Montgomery</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10620 Sweetbriar Pkwy.</b>				d. STREET ADDRESS <b>10620 Sweetbriar Pkwy.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES Milton</b>		First	Middle	Lost	4. DATE OF DEATH <b>10 - 3 -</b>	Month	Day	Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1910</b>	9. AGE (In years 50 last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VICE President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meekle Press</b>		11. BIRTHPLACE (State or foreign country) <b>San Antonio, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Allan K. Ragsdale</b>				14. MOTHER'S MAIDEN NAME <b>Ann Guyton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no rank own) <input checked="" type="checkbox"/> If yes give war or dates of service <b>U.S. Coast Guard WW II</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Bernice B. Ragsdale</b>		Address <b>10620 Sweetbriar Pkwy. Hillandale, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>976 X</b>				INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <b>Gunshot wound in head</b>		DUE TO		with Exsanguination					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>{</b>		(b)							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Depression</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased shot self in mouth with a 22 Cal. rifle, under Psychotherapy</b>							
20c. TIME OF INJURY Month, Day, Year <b>3pm 10-3 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. CITY OR TOWN (County) <b>Silver Spring Montgomery Md.</b>		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Peap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>Oct. 4 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. PEAP, M.D. Pathologist</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-Burial</b>		23b. DATE THEREOF <b>Oct. 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mission Burial Park</b>		23d. LOCATION (City or Town) <b>San Antonio, Texas</b>	
23e. MEDICAL DIRECTOR <b>C. Glen Carter</b>		23f. ADDRESS <b>8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		23g. REC'D BY REGISTRAR DATE <b>OCT 9 1967</b>		23h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14187

CERTIFICATE OF DEATH

14192

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 3 Mos. 2 das	
Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 6005 Roosevelt Street	
d. NAME OF DECEASED (Type or print) First Ethel		Last C. Reed	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH 10 12 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb. 13, 1880		10. AGE (In years last birthday) 87 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thatcher Slater		14. MOTHER'S MAIDEN NAME Sophia McCormick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Sister Eva L. Goebel		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myrenday Septem</i>		INTERVAL BETWEEN ONSET AND DEATH	
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Penalized this evening 5 hr</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Double Malaria</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 11, 1967</i> , to <i>10 Oct, 1967</i> that (I) (we) last saw the deceased alive on <i>Oct 11, 1967</i> , and that death occurred at <i>11:50 A.M.</i> from causes and on the date stated above.		22b. DATE SIGNED <i>12 Oct 67</i>	
22a. SIGNATURE <i>Jerome J. Daum</i>		22b. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Jerome J. Daum, M. D.		22d. ADDRESS 4977 Battery La., Beth., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-16-67	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

14183

14193

1. PLACE OF DEATH a. COUNTY  Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY Prince George	
c. LENGTH OF STAY IN lb 11 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross		d. STREET ADDRESS 1415 Legation Rd.,	
3. NAME OF DECEASED (Type or print) Harvey J. L. Reid		4. DATE OF DEATH Month 10 Doy 16 Year 1967	
5. SEX M. Wh.		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/14/21		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles William Reid		14. MOTHER'S MAIDEN NAME Eliza Drake	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 020-15-3107	
17. INFORMANT Dorothea Reid Hospital Records		Address 1415 Legation Rd., BPP	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9146 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Surface.		Generalized conflagration Burns of 90% of body	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Decapitated by gun in electrical flash type fire.	
20c. TIME OF INJURY Month, Doy, Year 12:30 p.m. 10-15 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office, bldg., etc.) Office		20f. (City or town) Silver Spring	
20g. (County) Montgomery		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10/16/67	
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR C. Glen Carter		25a. ADDRESS 334 Georgia Avenue	
25b. DATE Warner E. Pumphrey, Inc. Silver Spring, Maryland		25c. REC'D BY REGISTRAR OCT 19 1967	
25d. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

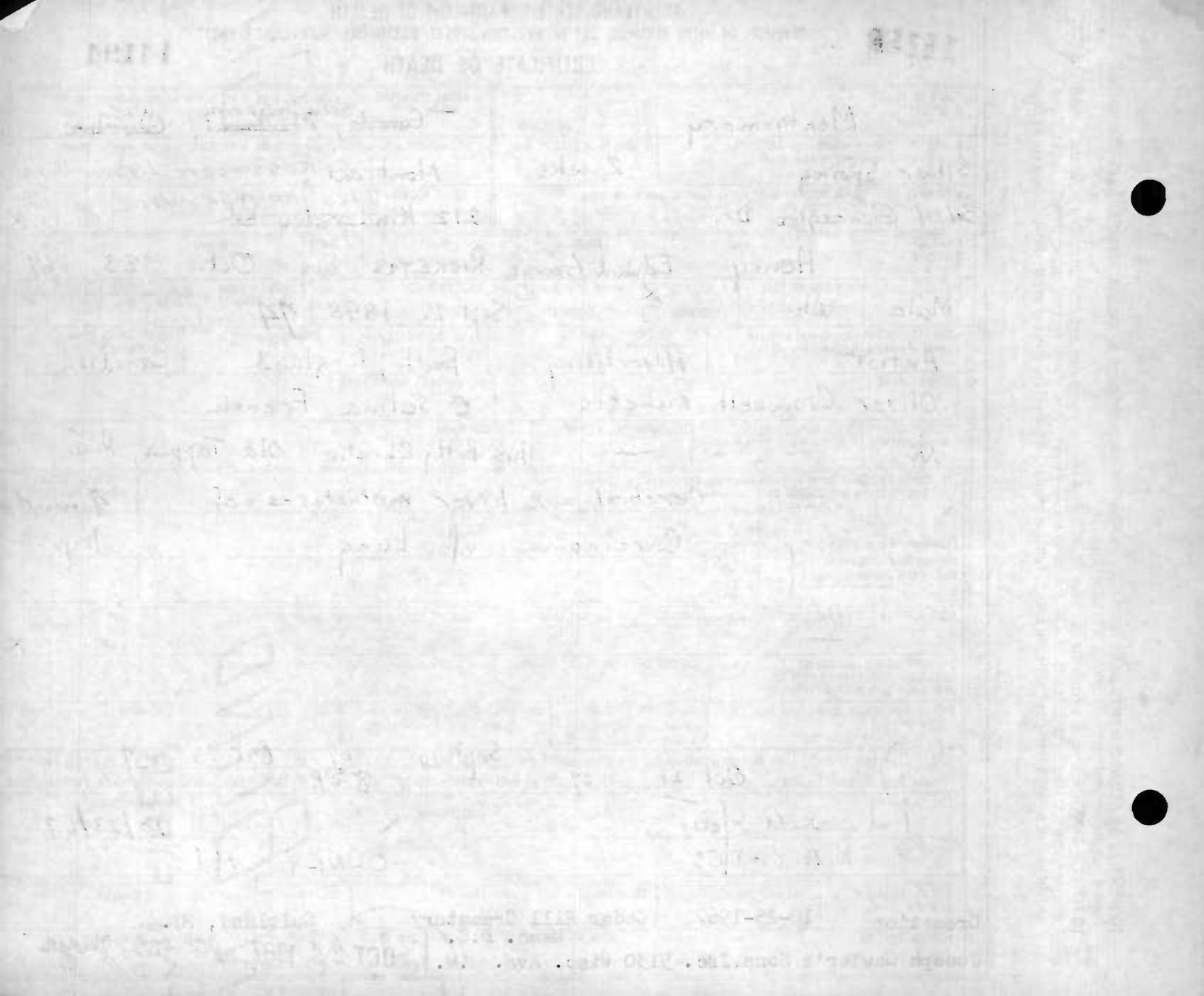
## CERTIFICATE OF DEATH

14194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Canada</u> , <u>Montreal</u> , <u>Quebec</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb 2 wks.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3424 Gleneagles Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <u>Henry</u>	Middle <u>Edward George</u>	Last <u>RICKETTS</u>	
4. DATE OF DEATH Oct.	Month 23	Day 1967	Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>	9. AGE (In years last birthday) <u>74</u> yrs.	11. BIRTHPLACE (County & State, or foreign country) <u>Bath England</u>	
13. FATHER'S NAME <u>Oliver Cromwell Ricketts</u>	14. MOTHER'S MAIDEN NAME <u>Selina French</u>	12. CITIZEN OF WHAT COUNTRY? <u>Canadian</u>	Address <u>h.s. Betty Christie Old Tappan, N.J.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>— — — — —</u>	17. INFORMANT <u>h.s. Betty Christie</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Cerebral and Liver metastases of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Lung.</u> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> , 1967, to <u>Oct 25</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 21</u> , 1967, and that death occurred at <u>8:30 P.M.</u> , from causes and on the date stated above.	22b. DATE SIGNED <u>10/23/67</u>			
22a. SIGNATURE <u>R. A. Yates</u>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <u>OLNEY, Md.</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. A. YATES</u>	23d. LOCATION (City or Town) (County) (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10-25-1967</u>	23c. NAME OF CEMETERY OR CREMATORIALY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>	ADDRESS <u>Wash. D.C.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE	
OCT 26 1967				



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14195

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
c. LENGTH OF STAY IN lb <i>4 Days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>5 MANAKEE Street</i>			
3. NAME OF DECEASED (Type or print) <i>Cora</i>		First <i>Bell</i>	Middle <i>Bell</i>	Lost <i>Rickman</i>	4. DATE OF DEATH <i>Oct 28 1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
8. DATE OF BIRTH <i>12/4/46</i>		9. AGE (in years last birthday) <i>80 yrs.</i>		10. IF UNDER 1 YEAR Months <i>12</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina USA</i>	
13. FATHER'S NAME <i>James M. Tallent</i>		14. MOTHER'S MAIDEN NAME <i>Robert C. Daddario</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address 1235 Falls Road, William Rickman - son Potomac, Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>A.S.H.D.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.H.F. &amp; PULMONARY EDEMA</i>		4.00 DUE TO <i>A.S.H.D.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>DIGITALIS TOXICITY</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>DIGITALIS TOXICITY</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Oct 27 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5413 CEDAR LANE BETHESDA MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>OCT 24 1967</i> to <i>OCT 28 1967</i> , that (I) (we) last saw the deceased alive on <i>OCT 27 1967</i> , and that death occurred at <i>10:10 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Robert C. Daddario</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>10/28/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO</i>		22d. ADDRESS <i>5413 CEDAR LANE BETHESDA MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/31/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery Silver Spring, Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rockville Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles J.</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles J.</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14191

## CERTIFICATE OF DEATH

14196

## 1. PLACE OF DEATH

o. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Boyds

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R.F.D. #1

## 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Boyds

151

d. STREET ADDRESS

R.F.D. #1

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
Daisy

Middle

Lost  
Riggs.4. DATE  
OF  
DEATHMonth  
Oct.Doy  
28Year  
1967

S. SEX

F

6. COLOR OR RACE

N

7. MARRIED  
WIDOWEDNEVER MARRIED  
DIVORCED

8. DATE OF BIRTH

June 28, 1892

9. AGE (In years  
lost birthday)  
yrs.

75

10. IF UNDER 1 YEAR  
Months

00

11. IF UNDER 24 HRS.  
Days

00

Hours

00

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S. A.

13. FATHER'S NAME

William Daye

14. MOTHER'S MAIDEN NAME

Maria Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Robert Riggs (husband) Same as item #2  
Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o)

4201

DUE TO

Conditions, if any, which gave  
rise to immediate cause (o).  
stating the underlying cause  
lost.

(b)

DUE TO

(c)

Acute Coronary Infarction.

INTERVAL BETWEEN  
ONSET AND DEATH

2. MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o.m.  
p.m. 1920d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1954, 19, to 10/28, 1967, that (I) (we) last  
saw the deceased alive on 10/27 1967, and that death occurred at 2:30 M, from causes and on the date stated above.

22a. SIGNATURE

L. I. Leal

22b. DATE SIGNED

22c. PHYSICIAN'S  
NAME (Type)

L. I. Leal

22d. ADDRESS

Gaithersburg, Md.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

24. FUNERAL DIRECTOR

ADDRESS

25a. REG'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

1000

HUNTING MADE EASY

1000



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14192

CERTIFICATE OF DEATH

14197

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>55 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Lloyd Roberts</b>		First <b>Edward</b>	Middle <b>Lloyd</b>
4. DATE OF DEATH <b>October 10 1967</b>	Month <b>October</b>	Day <b>10</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>9 July 1963</b>		9. AGE (In years last birthday) <b>4 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Rohme</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Neuroblastoma</b>		10 Months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 16, 1967</b> , to <b>Oct. 10, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 10, 1967</b> , and that death occurred at <b>5:45 M</b> , from causes and on the date stated above.		20f. (City or town) <b>(County)</b> <b>(State)</b>	
22a. SIGNATURE <b>Richard H. Creech</b>		A. M. M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>10 October 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard H. Creech, MD.</b>		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 13, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>(County)</b> <b>(State)</b> <b>Washington D C</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Judge</b>



4-1  
14193

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14198

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>3-DAYS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>3704 Brightview St</i>	
3. NAME OF DECEASED (Type or print) <i>Marmaduke David Robertson</i>		First <i>M</i>	Middle <i>David</i>
4. DATE OF DEATH <i>10/11/1967</i>	Month <i>10</i>	Day <i>11</i>	Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>3-29-91</i>
9. AGE (In years lost birthday) <i>70</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>electrician - retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Electrical Co.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Texas</i>	
13. FATHER'S NAME <i>Thomas Robertson</i>		14. MOTHER'S MAIDEN NAME <i>Maggie</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>579-03-2818</i>	17. INFORMANT <i>Carrie A. Robertson</i> Address <i>3704 Brightview St. Wheaton, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Oct 8</i> , 1967, to <i>Oct 11</i> , 1967, that (I) (we) last saw the deceased alive on <i>Oct 10</i> , 1967, and that death occurred at <i>3:30 AM</i> , from causes and on the date stated above.	
22a. SIGNATURE <i>Arn Smith</i>		22b. DATE SIGNED <i>10/11/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A.W. SMITH</i>		22d. ADDRESS <i>73018 Georgia Ave Wheaton, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 14, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ronnie Memorial Cemetery</i>
24. FUNERAL DIRECTOR <i>P. B. Thomas John &amp; Son Warren E. Pumphrey, Inc.</i>		23d. LOCATION (City or Town) (County) (State) <i>Amelia, Courthouse, Va.</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 13 1967</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

PAPERS

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14194  
CERTIFICATE OF DEATH

14199

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 3 hours/20 mins		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
						b. COUNTY <i>72</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi	
						d. STREET ADDRESS 6901 24 <sup>th</sup> Avenue	
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Martha		Middle Louisa		Last Rolls	
4. DATE OF DEATH Month October Year 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-30-79		9. AGE (In years last birthday) 88 yrs.	
13. FATHER'S NAME Samuel Chapman		14. MOTHER'S MAIDEN NAME Martha Futch		10. BIRTHPLACE (County & State, or foreign country) Ga.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-50-9166		17. INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause (c) DUE TO Atherosclerotic heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May, 1967, to Oct 3, 1967, that (I) (we) last saw the deceased alive on 10-3 1967, and that death occurred at 12:00 A.M., from causes and on the date stated above.							
22a. SIGNATURE <i>Robert B. TIREY</i>						22b. DATE SIGNED 10-4-67	
22c. PHYSICIAN'S NAME (Type) ROBERT B. TIREY		22d. ADDRESS 11161 New Hampshire Ave Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/7/67		23c. NAME OF CEMETERY OR CEMETORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md	
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14195

CERTIFICATE OF DEATH

14200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN 1b <b>1 yr. 3 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RANDOLPH HILLS NURSING HOME</b>		d. STREET ADDRESS <b>8619 Piney Branch Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>FRANCIS</b> Middle <b>ROONEY</b> Last		4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/30/90</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MODEL TESTER US. GOLF &amp; S. SURVEYOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTH PLACE (County, State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>ROONEY</b>		14. MOTHER'S M AIDEN NAME <b>Sharon Hunt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-46-2727A</b>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Acute Pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Pulmonary emphysema</b> YRS (c) DUE TO <b>Arteriosclerosis</b> <b>Habit</b> <b>smoker</b> YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY</b> , 19 <b>66</b> , to <b>OCT. 10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>OCT. 10</b> , 19 <b>67</b> , and that death occurred at <b>12 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Albert H. Grollman</b>		22b. DATE SIGNED <b>10/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT H. GROLLMAN</b>		22d. ADDRESS <b>1106 Spring St. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 13, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur L. Hatters Washington, D.C. 20012</b>		25a. RECD BY REGISTRAR <b>OCT 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jagger</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14195

CERTIFICATE OF DEATH

14201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. <sup>page 2</sup> and <sup>2</sup> should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>1101 Quebec St.</b>		
3. NAME OF DECEASED (Type or print) <b>Philip</b> First <b>R.</b> Middle <b>Rosen</b>			4. DATE OF DEATH Month <b>October</b> Day <b>14,</b> Year <b>1967</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1900</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cars</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Harry Rosen</b>			14. MOTHER'S MAIDEN NAME <b>- ANNA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>051-05-5327</b>		
17. INFORMANT <b>Elaine Lazaroff, daughter</b>			Address <b>2910 FENIMORE RD S.S. MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 14, 1967</b> to <b>OCT 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>OCT 14, 1967</b> , and that death occurred at <b>10:54 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Robert L. Krichmar</i>					
22b. DATE SIGNED <b>OCT. 14, 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR MD</b>		22d. ADDRESS <b>7733 ALASKA AVENUE NW WASHINGTON DC 20012</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/17/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Lebanon Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons Wash, D.C.</b>		25a. DATE <b>10/14/67</b>	25b. NAME BY REGISTRAR <b>2nd</b>	25b. REGISTRAR'S SIGNATURE <b>Glenda Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

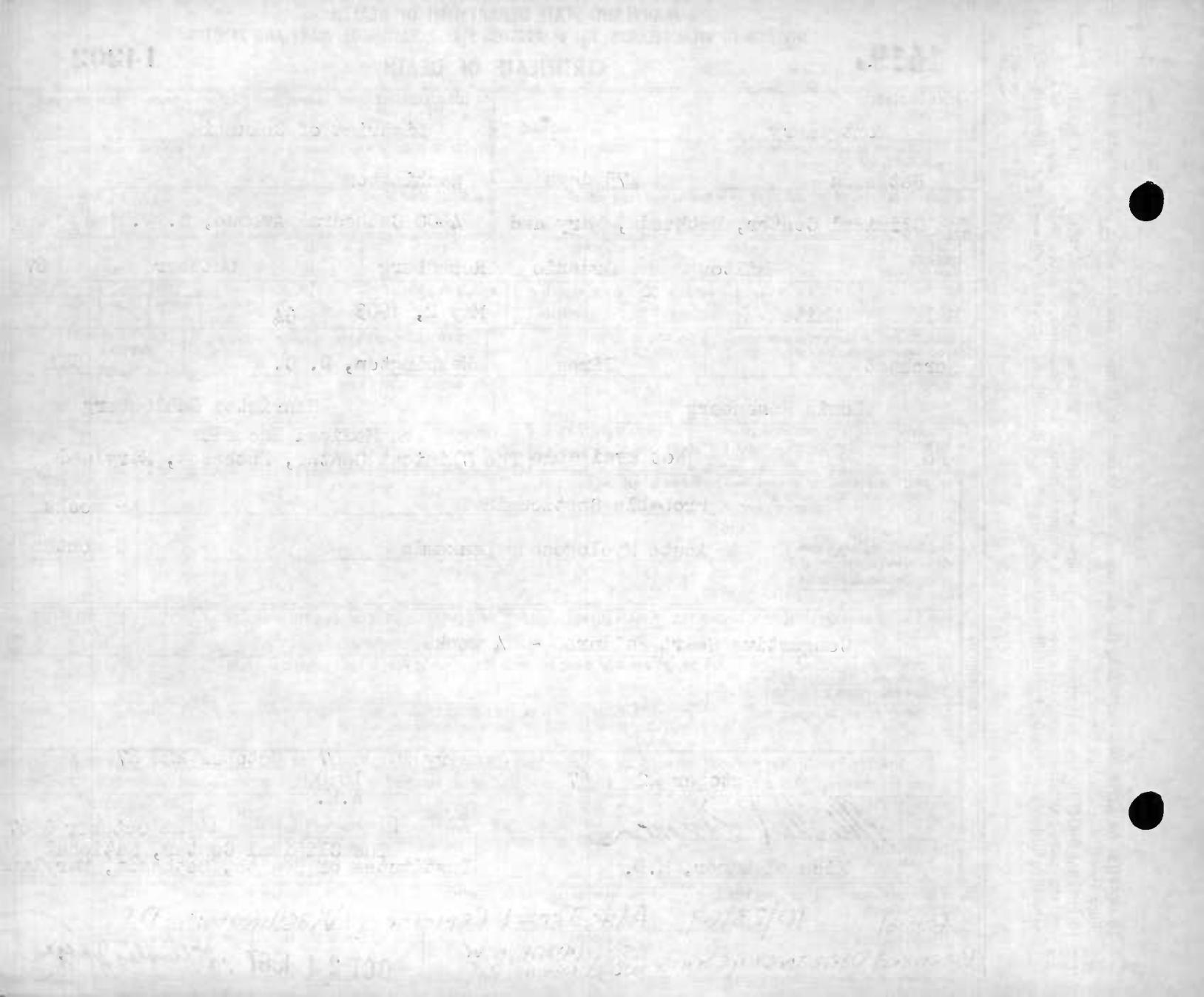
CERTIFICATE OF DEATH

**10**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**14197**

**14202**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>275 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>4000 Cathedral Avenue, N. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Milton</b>	Middle <b>Grunnie</b>	Last <b>Rosenberg</b>	4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>May 2, 1903</b>		9. AGE (In years last birthday) <b>64</b> yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tires</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Louis Rosenberg</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Not available</b>			
17. INFORMANT The Medical Records Address <b>The Clinical Center, Bethesda, Maryland</b>				18. ADDRESS			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2043</b> (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c)							
20. INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) <b>Congestive Heart Failure - 4 weeks</b>							
20b. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>January 20, 1967</b> , to <b>October 22, 1967</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>October 22, 1967</b> , and that death occurred at <b>10:00M</b> , from causes and on the date stated above. <b>A.M.</b>							
22o. SIGNATURE <b>Michael Emmer</b>				22b. DATE SIGNED <b>22 October 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Michael Emmer, M.D.</b>				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/23/67</b>		23c. NAME OF CEMETERY OR CEMINATORY <b>Adas ISRAEL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>		ADDRESS <b>3501-14th St., N.W. WASHINGTON, D.C.</b>		25o. REC'D. BY REGISTRAR <b>DATE OCT 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> D.C. b. COUNTY <b>MONTGOMERY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> Washington 473						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CLEARFIELD NURSING HOME</b>		d. STREET ADDRESS 1660 Lanier Pl. N.W.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH 10 - 29 Month Day Year 19 67						
3. NAME OF DECEASED (Type or print) <b>REBECCA LOUISE Ross</b>		First	Middle					
4. DATE OF DEATH	5. SEX <b>F.E.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. AGE (In years and birthday) <b>71</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
13. FATHER'S NAME <b>ABRAHAM ROSENBERG</b>	14. MOTHER'S MAIDEN NAME <b>FRANIE BERTHA ?</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>531-10-0514</b>	17. INFORMANT <b>AMY J. GENEKINS</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5401</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatic heart disease</b>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>10/30/1967</b>		ACTUAL SIG. NATURE <b>BELDEN R. REAP</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-1-1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>BETH DAVID CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>KAMONT, L.I., N.Y.</b>		
24. FUNERAL DIRECTOR <b>GOODELL FUNERAL HOME</b>		ADDRESS <b>4217 9TH ST. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14199		14204	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> , MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN lb <b>16 days</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland 20903</b>	
<b>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</b> <b>Colonial Villa Nursing Home, 12325 N. Hampshire</b>		<b>d. STREET ADDRESS</b> <b>1301 Oakview Drive</b>	
<b>3. NAME OF DECEASED (Type or print)</b> <b>Louise M.</b>		<b>First Ave., Silver Sp., Md.</b>	<b>Last</b> <b>Russell</b>
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7-19-84</b>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b></b>	
<b>11. BIRTHPLACE (Country &amp; State, or foreign country)</b> <b>Baltimore, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>Jacob Hemley</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Wildberger</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-01-1764-B</b>	
<b>17. INFORMANT</b> <b>Nursing Home Record</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) 4221</b> <b>Due to</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 4221</b> <b>Due to</b> <b>stating the underlying cause (c) 4221</b> <b>Due to</b> <b>Arteriosclerotic C.V.D.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 hr.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Bladder hemorrhage</b>		<b>19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)</b>	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b></b>	
<b>20c. TIME OF INJURY Month, Day, Year</b> <b>Hour a.m. 10 p.m. 19</b>		<b>20d. INJURY OCCURRED</b> <b>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></b>	<b>20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)</b> <b></b>
<b>21. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 10-4, 1967, that (I) (we) last saw the deceased alive on 10-2 1967, and that death occurred at 2:40 PM, from causes and on the date stated above.</b>		<b>20f. (City or town) (County) (State)</b> <b></b>	
<b>22a. SIGNATURE</b> <b>R. D. Bauer, M.D.</b>		<b>M.D. ATTENDING PHYS.</b> <b><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	<b>22b. DATE SIGNED</b> <b>10-4-67</b>
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>R. D. Bauer, M.D.</b>		<b>22d. ADDRESS</b> <b>2513 Buckledge Rd. Beltsville, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>10/9/67.</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Waugh Chapel Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Glen Arm, Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Leonard J. Ruck, Inc. Beltsville, Md. 21214</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE OCT 5 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14200

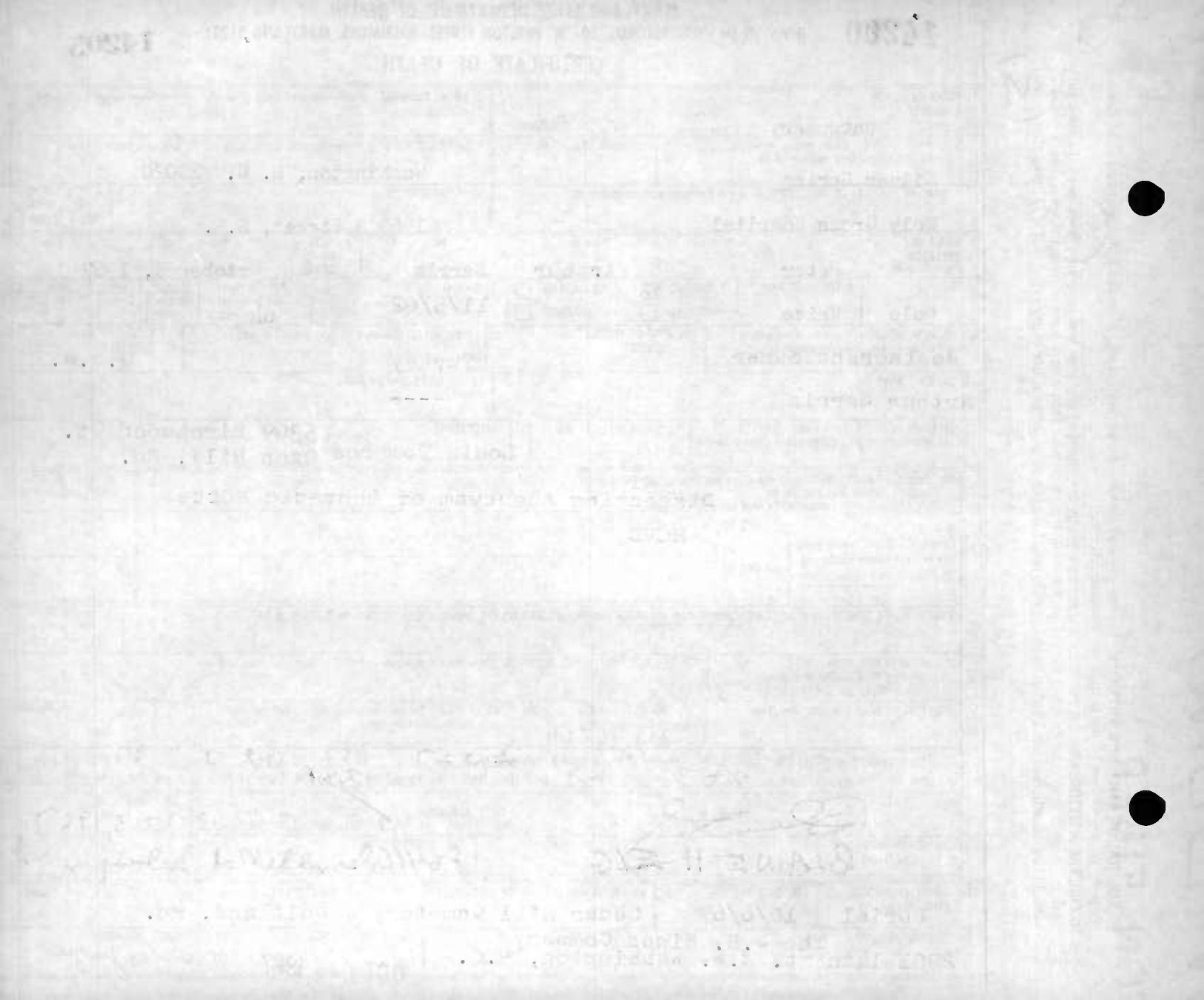
14205

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> 20020	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> 20020	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1950 S Street, S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		47-3	
3. NAME OF DECEASED (Type or print) <b>Peter</b>		First <b>Arthur</b>	Middle <b>Sarris</b>
4. DATE OF DEATH <b>October 3, 1967</b>		5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/5/02</b>	
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant owner</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Turkey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Arthur Sarris</b>	
14. MOTHER'S MAIDEN NAME <b>-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Louis Tompros</b> 5309 Birchwood Ct. Oxon Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm of thoracic aorta</b> INTERVAL BETWEEN ONSET AND DEATH 443X DUE TO <b>HCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO <b>HCVD</b> stating the underlying cause (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 27</b> , 1967, to <b>Oct 3</b> , 1967, that (I) (we) last saw the deceased alive on <b>Oct 3</b> 1967, and that death occurred at <b>2:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Oct 3, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. HINES</b>		22d. ADDRESS <b>8641 Glendale Rd, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/6/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE <b>OCT 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



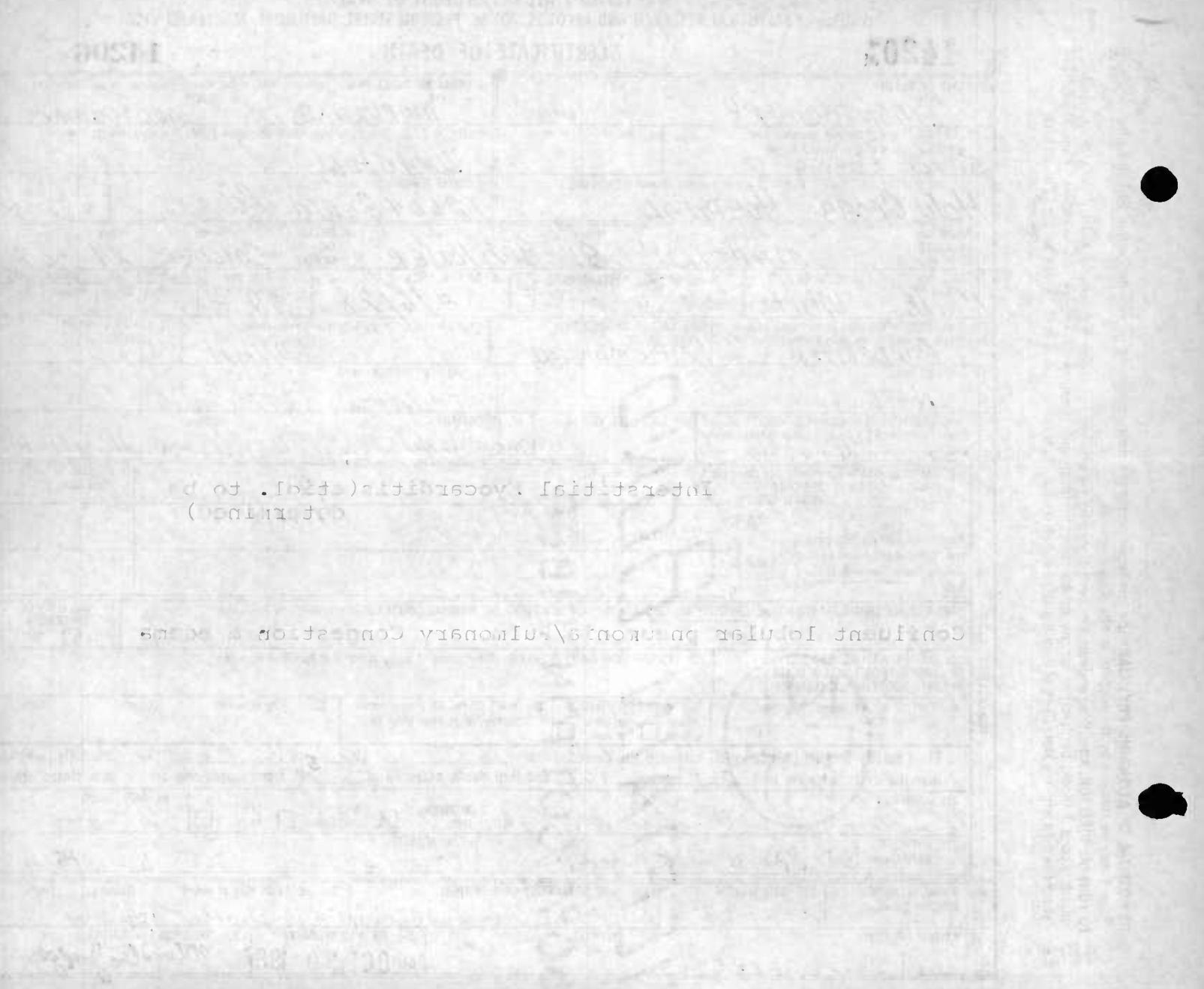
14201

## CERTIFICATE OF DEATH

14206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>12604 Gould Rd.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			151		
3. NAME OF DECEASED (Type or print)	First <b>MARTIN</b>	Middle <b>S. Schloner</b>	Last <b>October 24</b>	Month <b>1967</b>	Day Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/28</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MINN.</b>	
13. FATHER'S NAME <b>Nathan</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Fechner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes Korean</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Betty Schloner (wife) 12604 Gould Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>431X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>determined</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Confluent lobular pneumonia/Pulmonary Congestion &amp; edema</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 21, 1967</b> to <b>Oct 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 24, 1967</b> , and that death occurred at <b>630 M</b> , fram causes and on the date stated above.					
22a. SIGNATURE <b>Edward J. Richards</b>					
22b. DATE SIGNED <b>10-24-67</b>					
22c. PHYSICIAN'S NAME (Type) <b>EDWARD J. RICHARDS</b>		22d. ADDRESS <b>1011 GEORGIA AVE. SIL. 5A-172</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-27-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>King David Memorial Garden</b>	23d. LOCATION (City or Town) <b>Falls Church, Virginia</b>	(County)	(State)
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>			ADDRESS <b>3801 14th St. NW</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE
				DATE <b>OCT 30 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, tremotion, or removal, and in any event, within 72 hours after death.

14202		14207	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>3 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8802 Lowell Place</b>		e. STREET ADDRESS <b>8802 Lowell Place</b>	
3. NAME OF DECEASED (Type or print) <b>ETHYL</b>		First <b>ETHYL</b>	Middle <b>SCHWARTZ</b>
4. DATE OF DEATH <b>Oct. 2, 1967</b>		Month <b>Oct.</b>	Doy <b>2</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Aug. 24, 1884</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Golden, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Scott Taylor</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE SELBY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter</b>		Address <b>Ada Schwartz</b> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO <b>Meta-static-Carcinoma. of Liver -</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AdenoCarcinoma. of Colon.</b> (c) <b>2 1/2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1967</b> to <b>Oct. 1967</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>2 Oct 1967</b> , and that death occurred at <b>4 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John G. Ball</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>		22d. ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Hebron Cemetery</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, BETHESDA, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

YERKES JACOB

BB-11222

TRIANGULATION

REBANSON

BB-11223

TRIANGULATION

1914 HOWARD BOBB

BB-11224

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TRIANGULATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14208

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

14203		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
1. PLACE OF DEATH		o. STATE			b. COUNTY						
o. COUNTY		MARYLAND			MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
TAKOMA PARK		28 days			SILVER SPRING						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?						
Washington SANITARIUM + Hospital		8505 SPRINGVALE Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (First, Middle, Last)		4. DATE OF DEATH			Month Doy Year						
First		Last			Month Doy Year						
Ralph ALVIN Simmons		October 20 1967			IF UNDER 1 YEAR IF UNDER 24 HRS.						
5. SEX		6. COLOR OR RACE		7. MARRIED		B. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.			
MALE		White		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		4-16-90		77 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
ACCOUNTANT		UNIV. OF MD.		WISCONSIN		AMERICA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Rush Simmons		NELLIE HARRIS		YES. World War I		219-36-9334		PATIENT'S CHART.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		P. S. Bleeding Left Duodenal Ulcer		INTERVAL BETWEEN ONSET AND DEATH			
177X		DUE TO		(b)		Adeno Carcinoma, Prostate		48 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)		DUE TO		1 year		1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		Ayotenia		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		22b. DATE SIGNED			
19		10/16 1967		10/16 1967		10/20 1967		10/20 1967			
21. I certify that (I) (this hospital) attended the deceased from 10/16 1967 to 10/20 1967 that (I) (we) last saw the deceased alive on 10/16 1967 and that death occurred at 3:00 P.M. from causes and on the date stated above.		22a. SIGNATURE		M.D. ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.			
22c. PHYSICIAN'S NAME (Type)		Douglas K. Potts, M.D.		22d. ADDRESS		831 University Blvd. S.W.		10/20 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CEMETORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR			
Burial		Oct 24, 1967		Sunset Memorial Cemetery		St Paul Minnesota		25b. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR		ADDRESS		DATE		OCT 23 1967		Charles J. Jagger			
F. Gasch's Sons		Hyattsville, Md.		ADDRESS		DATE		OCT 23 1967			

2021-4

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14209

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 26 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14204		CERTIFICATE OF DEATH		14209	
<p>1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b></p> <p>c. LENGTH OF STAY IN lb <b>13 days</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b></p>		<p>d. STREET ADDRESS <b>Route 1, Box 86-7</b></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <b>Dale</b></p>		First <b>Dale</b>	Middle <b>Edward</b>	Last <b>SMITH</b>	4. DATE OF DEATH <b>October 23</b>
<p>5. SEX <b>Male</b></p>		6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 10, 1959</b>	9. AGE (In years last birthday) <b>8 yrs.</b>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Key West Florida</b></p>	
<p>13. FATHER'S NAME <b>Rufus E. Smith</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Virgie Mason</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b></p>		<p>16. SOCIAL SECURITY NO. <b>None</b></p>		<p>17. INFORMANT <b>Park, Maryland</b> Address <b>Rufus E. Smith, Route 1, Box 86-7 Lexington</b></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>296X</b> <i>Human Blood Failure</i> INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <b>He</b> <i>Uremia</i></p> <p>(c) <b>Diaphragmatic Paralysis</b></p>					
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>					
MEDICAL CERTIFICATION		<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> 20d. INJURY OCCURRED p.m. <b>19</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) <b>Oct. 10, 1967</b> (County) <b>Oct. 23, 1967</b> (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 10, 1967</b> to <b>Oct. 23, 1967</b>, that (s) (we) last saw the deceased alive on <b>Oct. 23, 1967</b>, and that death occurred at <b>215PM</b>, from causes and on the date stated above.</p>					
<p>22a. SIGNATURE <i>F. X. Loeb</i></p>		<p>M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></p>		<p>22b. DATE SIGNED <b>Oct. 24, 1967</b></p>	
<p>22c. PHYSICIAN'S NAME (Type) <b>F. X. LOEB, M.D.</b></p>		<p>22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>10-28-67</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORIALY <b>City Cemetery</b></p>	
<p>24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.</b></p>				<p>25a. REC'D BY REGISTRAR <b>Charles J. Charles</b></p>	
				<p>25b. REGISTRAR'S SIGNATURE <i>Charles J. Charles</i></p>	

44528

4746-10 HANFORD

4030

4

near forest

open ground

very localized

soil

(100%) loose soil

1-25 and 2-30cm

calcareous layer

leaching

lime

brown

red

0-10cm. fine granular surface soil, 10-20cm. sand

soil

red

subangular block soil

red

coarse granular

lime, sand

loose soil

calcareous

lime, sand

calcareous bed and 2-30cm. fine granular soil

soil

10-20cm. fine granular soil

lime, sand

soil

lime, sand

calcareous fine granular soil

lime, sand

calcareous fine granular

lime, sand

0-10cm. fine granular soil, 10-20cm. fine granular soil, 20-30cm. fine granular soil

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

6  
#  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 16 <i>48 hr.</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>4411 Ives Street</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Irene</i>		Middle <i>F.</i>	Last <i>Smith</i>		
4. DATE OF DEATH Month <i>Oct.</i>	Month <i>28</i>	Day <i>1967</i>	Year		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>5/12/12</i>	9. AGE (In years last birthday) <i>55 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESWOMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>STORE</i>			
11. BIRTHPLACE (County & State, or foreign country) <i>MONTGOMERY Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>CHARLES P. SCHARRER</i>		14. MOTHER'S MAIDEN NAME <i>LELA GOODING</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>William E. Smith</i>			
17. INFORMANT <i>William E. Smith</i>		Address <i>4411 Ives St., Rockville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intrapontine Hemorrhage</i> DUE TO <i>443 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10/28/67</i>	
20f. (City or town) <i>Rockville</i>		(County) <i>Md.</i>		(State) <i>1967</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>10/28/67</i> to <i>10/28/67</i> , 1967, that (II) (we) lost saw the deceased alive on <i>10/28/67</i> , and that death occurred at <i>5:00 pm</i> from causes and on the date stated above.				22b. DATE SIGNED <i>10/28/67</i>	
22a. SIGNATURE <i>John J. Curry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>		22d. ADDRESS <i>10620 Georgia Avenue</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/1/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	
23d. LOCATION (City or Town) <i>Rockville</i>		(County) <i>Maryland</i>		(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>J. Wm. Lees Sons. 300 4th St. NE, Wash.</i>		ADDRESS <i>DC 20001</i>		25a. REC'D BY REGISTRAR <i>OCT 31 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2031

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14208

## CERTIFICATE OF DEATH

14211

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
3. NAME OF DECEASED (Type or print) First Ted Middle Theodore SMITH		4. DATE OF DEATH Month October Doy 18 Year 1967	
5. SEX Male Cauc		6. COLOR OR RACE 7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 8, 1910		9. AGE (In years lost birthday) 57 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME ? Lynn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1927-1954		16. SOCIAL SECURITY NO. 220 34 3815	
17. INFORMANT Lexington Park Address Md. Mrs. Emma W. Smith, 313 Yorktown Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d. INJURY OCCURRED p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from Oct. 12, 1967 to Oct. 18, 1967, that (b) (we) last saw the deceased alive on Oct. 18, 1967, and that death occurred at 945A M, from causes and on the date stated above.		22. SIGNATURE Lawrence W. Raymond M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED Oct. 19, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Mattingly Funeral Home ADDRESS Leonardtown, Md. W. Clarke Mattingly		25a. REC'D BY REGISTRAR DATE OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

11351

100-10-10015

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14207

14212

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>1 Valley View Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		151	
3. NAME OF DECEASED (Type or print)	First <i>Albert</i>	Middle <i>Austin</i>	Last <i>Spear</i>
4. DATE OF DEATH Month <i>October</i>	Month <i>23</i>	Day <i>1967</i>	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7/3/94</i>	9. AGE (In years lost birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Treasury Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>Albert Spear</i>		14. MOTHER'S MAIDEN NAME <i>Emma Austin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220 34 8572</i>	
17. INFORMANT <i>Mrs. Mary Eleanor Spear (same as #2)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5271</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cor pulmonale - Congestive heart failure</i>		DUE TO <i>6 weeks.</i>	
(c) <i>Chronic pulmonary emphysema.</i>		6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on <i>10/22 1967</i> , and that death occurred at <i>10:55 AM</i> , from causes and on the date stated above.		21. DATE SIGNED <i>10/23/67</i>	
22a. SIGNATURE <i>James R. Coleman MD.</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/23/67</i>
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>		22d. ADDRESS <i>9241 COLUMBIA BLVD. SPRING, MD.</i>	SILVER
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 26, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		25a. ADDRESS <i>Wash. D.C.</i>	25b. REC'D BY REGISTRAR DATE <i>OCT 26 1967</i>
Takoma Funeral Home		25b. REGISTRAR'S SIGNATURE <i>J. Charles Juge</i>	

2000-01-02

p. 11

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14203

## CERTIFICATE OF DEATH

14213

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>35 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>Apt. 1301, 10500 Rockville Pike</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Helen</b>		First	Middle
		Last	4. DATE OF DEATH <b>STAFFORD</b> October 09 1967
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreign Service</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Alton C. Hawkes</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Sawyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>027-20-8374</b>	
17. INFORMANT <b>Derwood G. Stafford, Apt. 1301 10500 Rock-</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA, LEFT LOWER LOBE</b> DUE TO 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIOMEGLY, Primary Myocardial Disease</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Sept. 4, 1967</b> , to <b>October, 1967</b> that (X) (we) lost the deceased alive on <b>October 9, 1967</b> , and that death occurred at <b>905 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>10 Oct. 1967</b>	
22a. SIGNATURE <b>L. W. Raymond, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>L. W. RAYMOND, M. D.</b> <b>LT-Jr-Dr-ZIMMERMAN,</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, Cremation		23b. DATE THEREOF <b>10-11-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fort Lincoln Crematory</b>
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR <b>Oct 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14208

## CERTIFICATE OF DEATH

14214

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pogs and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington.</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>555 Thayer Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium.</b>			d. STREET ADDRESS <b>Sil. Spring, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>BELLE</b>	Middle <b>E</b>	Last <b>STERNE</b>	4. DATE OF DEATH	Month <b>OCT.</b>	Day <b>19</b>	Year <b>1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9/14/85</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H-Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manuel</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT <b>Louis B. Sterne - same as #2</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC MYOCARDITIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>DIABETES MELLITIS</b>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1966</b> to <b>October 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 19, 1967</b> , and that death occurred at <b>4:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Henry W. Lowden</b>				22b. DATE SIGNED <b>OCTOBER 19, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry W. Lowden</b>		22d. ADDRESS <b>5206 Novette Dr., Chevy Chase, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/23/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Gate of Heaven</b>		23d. LOCATION (City or town) (County) (State) <b>Wheaton, Md.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers, Inc.</b>		14208 Chapel St. #100 Wheaton, Md. 20701		25a. REC'D BY REGISTRAR <b>DATE OCT 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

14210		14215	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>50 mins.</u>		b. COUNTY <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Nina STEWART</u>		First	Middle
4. DATE OF DEATH <u>Oct. 12 1967</u>		Last	Month
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <u>4/29/1907</u>
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>99 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ontario, Canada</u>	
13. FATHER'S NAME <u>William James Stewart</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-66-9618</u>	
17. INFORMANT <u>John E. Taylor, Same as # 2</u>		18. ADDRESS	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) <u>Cardiac tamponade</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span> due to <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction with Rupture</u> due to <u></u> (c) <u>Coronary Arteriosclerosis Severe</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) <u>Diabetes Mellitus</u> 2) <u>Hypertension, mod. severe.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (1) <u>Stewart Clapp M.D.</u> attended the deceased from <u>1967</u> to <u>Oct 12 1967</u> , that (1) <u>we</u> last saw the deceased alive on <u>Oct 12 1967</u> , and that death occurred at <u>5130 Chevy Chase Dr.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp M.D.</u>		22b. DATE SIGNED <u>10-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr.</u> <u>Chevy Chase, Md. 20015</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) <u>Washington, D.C.</u> (County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C. 20016</u>		25a. ADDRESS <u>5130 Wisconsin Ave., NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REC'D BY REGISTRAR <u>OCT 18 1967</u>	

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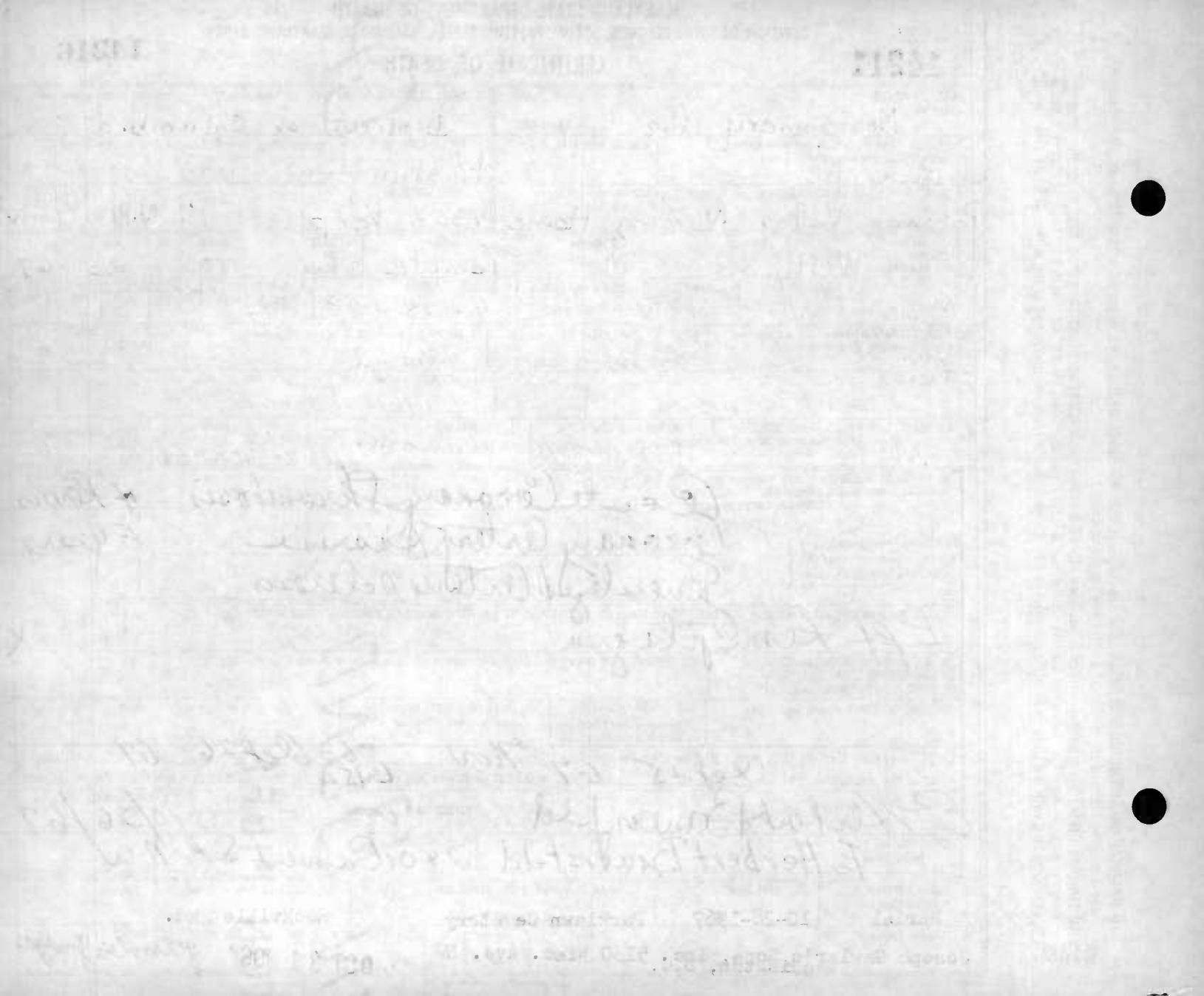
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14211 CERTIFICATE OF DEATH 14216

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers pages 1 and 2. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>4353 Verplanck Pl N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1967</b>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>M.</b>	Last <b>Temple</b>
4. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-93</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mfg. Representative</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Temple</b>		14. MOTHER'S MAIDEN NAME <b>Ludell Perry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>278-01-2198</b>	
17. INFORMANT <b>William W. Temple - Son - 11317-Mirschler St.</b>		Address <b>KENNINGTON MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Acute Coronary Thrombosis</b>		4 hours	
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Artery Disease</b>		5 years	
(c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized Arterio Sclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Left hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1963, Oct 26, 1967</b> (County) <b>Rockville, Md.</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1963, Oct 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 25, 1967</b> , and that death occurred at <b>15A</b> M, from causes and on the date stated above.		22b. DATE SIGNED <b>10/26/67</b>	
22a. SIGNATURE <b>E. Herbert Bauersfeld</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>E. Herbert Bauersfeld</b>		22d. ADDRESS <b>2401 Calvert St. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-28-1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) <b>Rockville, Md.</b> (County) <b>Md.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave. NW</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>OCT 31 1967</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14217

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. STATE <i>Va</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb <i>12 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Potomac Valley Mem Home Rockville</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ALEXANDRIA</i>	
3. NAME OF DECEASED (Type or print) <i>WILLIAM</i>		d. STREET ADDRESS <i>900 PENDLETON ST.</i>	
4. DATE OF DEATH <i>10/16/67</i>	Month <i>10</i>	Day <i>16</i>	Year <i>1967</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/22/1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Culpepper, Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>UNknown</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>223-40-1086</i>	
17. INFORMANT <i>Alexandria Welfare Dept. Alex, Va.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anaplastic adenocarcinoma, mediastinal 6 mos.</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/3/67</i> to <i>10/16/67</i> , 19....., that (I) (we) last saw the deceased alive on <i>10/15/67</i> , 19....., and that death occurred at <i>8:00 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>George C. Crossland M.D.</i>		22b. DATE SIGNED <i>10/16/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Henry C. Crossland M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>5443 Cedar Lane Bethesda Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/17/67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>King Hill</i>		23d. LOCATION (City, town or county) <i>Alexandria, Va</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wesley Greene 814 Franklin</i>		25e. REG'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Wesley Greene 814 Franklin</i>	
ADDRESS <i>Wesley Greene 814 Franklin</i>		DATE <i>10-16-67</i>	

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FOR STATE  
HEALTH DEPT.

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14218

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5300 Ellicott Rd.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Alonzo</i>		First <i>None</i>	Middle <i>Thompson</i>
4. DATE OF DEATH <i>Oct - 24 1967</i>		Month <i>Oct</i>	Day <i>24</i>
5. SEX <i>M.</i>		6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>April 25, 1904</i>		9. AGE (In years lost birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour.</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John E. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <i>10/24/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>out 28, 1967</i>		23b. DATE THEREOF <i>out 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Silver Spring</i>
23d. LOCATION (City or Town) <i>Silver Spring</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Grogin 389 B.I. Crem. Co.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>NOV 1 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14214		14219	
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>4 yrs. 3 mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5505 Charlote Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS HILDRETH TRICKETT</b>		First Middle Last	4. DATE OF DEATH <b>October 27, 1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 27, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13. FATHER'S NAME <b>Edward T. Trickett</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>145-10-0114</b>	
17. INFORMANT <b>Son</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>Hypertensive Arterosclerotic Heart Disease</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>(County)</b> <b>(State)</b>		21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>63</b> , to <b>October 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-13 1967</b> , and that death occurred at <b>9A M</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>		22b. DATE SIGNED <b>10-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLAINE FITZGERALD</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-30-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>First Baptist Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Salem, New Jersey</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 30 1967</b>	

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教育文化 2001 年第 1 期

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14220

14213

## CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dist. of Col.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 21 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3925 - Davis Place, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing Home 4011 Randolph Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: Alice Middle: Muriel Last: TULLOCH		4. DATE OF DEATH Month: 10 Day: 24 Year: 1967	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-13-1901		9. AGE (In years lost birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registrar		10b. KIND OF BUSINESS OR INDUSTRY Pakistan Embassy	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD S. LAWTON		14. MOTHER'S MAIDEN NAME Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 579-58-4071	
17. INFORMANT TULLOCH		18. ADDRESS 20 Upton St. N.W.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RT BREAST</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955, to Oct 24, 1967, that (I) (we) last saw the deceased alive on Oct 23 1967, and that death occurred at 9:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED Oct 24, 1967	
22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter		22d. ADDRESS 3848 Porter St. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-27-1967	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. ADDRESS Wash. D.C. 5130 Wisconsin Ave. N.W.	
25b. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Item 2 Film 399 4-5-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14221

14216

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 13 <sup>1</sup> / <sub>2</sub> hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland D.C.		b. COUNTY Prince George's Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 826 - 46th St. N.E. Belmont Nursing Home 17220 New Hampshire Ave.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 826 - 46th St. N.E. Silver Spring		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Female Ida		First Middle		4. DATE OF DEATH Tyson Oct. 13 1967		Last Month Day Year			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-7-01		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Belmont Nursing Home Hospital Records MGH		Address Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT, RECURRENT</u>								INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UREMIA & HEMIPLEGIA								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Nursing Home		20f. (City or town) (County) (State) 10/13/67			
21. I certify that (I) (this hospital) attended the deceased from 10/12/67 to 10/13/67, that (I) (we) last saw the deceased alive on 10/12/67, and that death occurred on 10/13/67 M, from causes and on the date stated above.									
22o. SIGNATURE <u>Dr. Charles Ligon</u>									
22c. PHYSICIAN'S NAME (Type) Dr. Charles Ligon		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 10/13/67			
23a. CERIAL, CREMATION, REMOVAL (Specify) Burial, Cremation, Removal (Specify)		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORIUM HARMONY MEMORIAL PRINCE GEORGE MD.		23d. LOCATION (City or Town) (County) (State) Prince George MD.			
24. FUNERAL DIRECTOR Burial, Cremation, Removal (Specify) Davidson		ADDRESS 5635 1/2 Eads St. N.E., Wash. 19.D.C.		25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #6393 10/16/67 ph

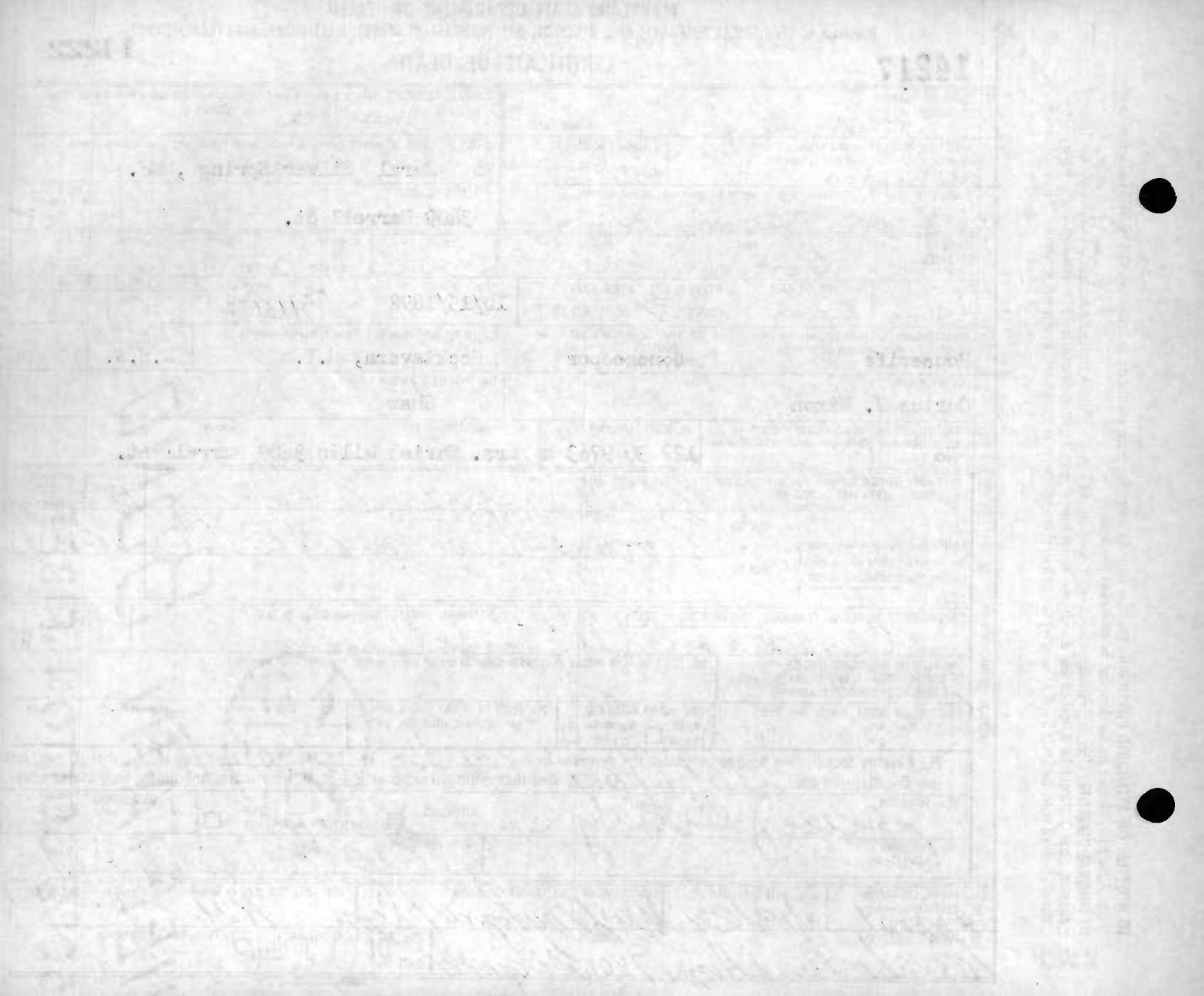
14222

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		14217		2		2		3		4		5		6		7		8		9		10															
1. PLACE OF DEATH		o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		o. STATE		New York		b. COUNTY		14222		14222		14222		14222		14222		14222													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2 yrs, 6 mon. 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Silver Spring, Md.		69 3		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		wheaton		wheaton Nursing Home		d. STREET ADDRESS		d. STREET ADDRESS		3409 Harrell St.		69 3		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year		3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year							
S. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years at last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		S. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years at last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.							
Female		Cane		WIDOWED		<input checked="" type="checkbox"/> DIVORCED		10/15/1892		74 yrs		Months		Days		Hours		Female		Cane		WIDOWED		<input checked="" type="checkbox"/> DIVORCED		10/15/1892		74 yrs		Months		Days		Hours			
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		Homekeeper		11. BIRTHPLACE (County & State, or foreign country)		Rocktavern, N.Y.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.		100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		Homekeeper		11. BIRTHPLACE (County & State, or foreign country)		Rocktavern, N.Y.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.							
13. FATHER'S NAME		Curtus M. Wixon		14. MOTHER'S MAIDEN NAME		Shaw		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		13. FATHER'S NAME		Curtus M. Wixon		14. MOTHER'S MAIDEN NAME		Shaw		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		122 30 9783 a		Mrs. Muriel Mills 3409 Harrell St.																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:																		491X		491X		491X		491X		491X		491X		491X		491X		491X			
IMMEDIATE CAUSE (a)		DUE TO		Bacteriopneumonia														491X		491X		491X		491X		491X		491X		491X		491X		491X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		Congestive Heart Failure												491X		491X		491X		491X		491X		491X		491X		491X		491X			
(c)																																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		Cerebral Arteriosclerosis																		19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)																																					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
Hour o.m.		While		Not While														20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
p.m.		of work		of work														19																			
21. I certify that (I) (this hospital) attended the deceased from 10/16/67, 19, to 10/16/67, 19, that (I) (we) last saw the deceased alive on 10/16/67, 19, and that death occurred at 219 M, from causes and on the date stated above.																																					
22a. SIGNATURE		John J. Curry		22b. DATE SIGNED																																	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		10620 Georgia Avenue																															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)												23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)													
24. FUNERAL DIRECTOR		ADDRESS		25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE												24. FUNERAL DIRECTOR		ADDRESS		25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Lassabo 700 1 Hwy 7401 Belair Rd				801 13 1967		Charles Judge												Lassabo 700 1 Hwy 7401 Belair Rd				801 13 1967		Charles Judge													



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14223  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11212		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND						
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b> MARYLAND		a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>						
c. LENGTH OF STAY IN 1b <b>1 1/2 mos.</b>		d. STREET ADDRESS <b>6916 D St.,</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>University Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Edward Franklin Vann</b>		First	Middle	Last	4. DATE OF DEATH <b>October 20</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1895</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Columbia Furnace, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Vann</b>		14. MOTHER'S MAIDEN NAME <b>Frances Miller</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Michael F. Vann</b>		Address <b>Same As #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the esophagus</b>								
150X DUE TO Conditions, If any, which gave rise to Immediate cause (e), stating the underlying cause last. (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>115 A.M.</b>	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> , to <b>Oct 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 20, 1967</b> , and that death occurred at <b>115 A.M.</b> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Lawrence J. Ruberman</i>		22b. DATE SIGNED <b>10/20/67</b>						
22c. PHYSICIAN'S NAME (Type) <b>William Brainin, M.D.</b>		22d. ADDRESS <b>6124 Central Ave., Capitol Heights, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/23/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Prince Georges, Md.</b>			
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25a. ADDRESS 25b. REGISTRAR'S SIGNATURE <b>DATE OCT 25 1967</b> <i>Charles Judge</i>						

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**MARYLAND STATE DEPARTMENT OF HEALTH  
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## **CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To Hospital Director:** After this certificate has been signed by the attending physician and completely filled in by the attending physician, **remove** carbon paper. **Pages 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and **any event**, within 72 hours after death.

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY		Montgomery, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		Md		b. COUNTY		Prince Georges		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		C. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		162						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		5 1/2 months		d. STREET ADDRESS		Jacqueline Park						
Colonial Villa Nursing Home		903 Ann St		e. IS RESIDENCE ON A FARM?								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
Emma E. Vonasch					OCTOBER	20		1967				
5. SEX		6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
Fem		White	WIDOWED	<input type="checkbox"/>	<input type="checkbox"/>	February 24 1893	74 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY						
Homemaker		at Home		Illinois		U.S.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
Fred Engel		Anna										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		INTERVAL BETWEEN ONSET AND DEATH				
No		MA 708-03-6475		William F. Vonasch (same as 12)				8/1/1967				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		By perforation of pneumonia										
715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Hemorrhage due to perforation of pelvic area		DUE TO (c)			11 months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 2/13/1967 to 10/20/1967, that (I) (we) last saw the deceased alive on 10/20/1967, and that death occurred at 1:30 P.M. from the causes and on the date stated above.												
22a. SIGNATURE												
Howard Morse												
22c. PHYSICIAN'S NAME (Type)		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>						
Howard T Morse				22d. ADDRESS		Carroll Ave, Takoma Park		Md		10/20/67		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town or county) (State)
Burial	Oct 25, 1967	Oakland Memorial Park	Dolton, Illinois
24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
John W. Walters	Oct 23, 1967	John W. Walters	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>4608 Merivale Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Walter C Von Brant</i>		4. DATE OF DEATH Month <i>October</i> Day <i>25</i> Year <i>1967</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Male</i> 6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>3/3/91</i>	9. AGE (In years lost birthday) <i>76 yrs.</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <i>Electrical Engineer</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Walter C Von Brant</i>		14. MOTHER'S MAIDEN NAME <i>Anna Meyer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-03-720</i>	
17. INFORMANT <i>Mrs Ruth Day - 3064 Hazelton St -</i>		Address <i>Falls Church VA</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>4201</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerosis with occlusion</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Falls Church</i> (County) <i>VA</i> (State) <i>VA</i>		21. I certify that (I) (this hospital) attended the deceased from <i>10/24/67</i> to <i>10/25/67</i> , that (I) (we) last saw the deceased alive on <i>10/25/67</i> , and that death occurred at <i>15P</i> M, from causes and on the date stated above.	
22a. SIGNATURE <i>Robert R. Montgomery</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED <i>10/26/67</i>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22d. ADDRESS <i>5411 CEDAR LANE BETHESDA</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>10-28-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cemetery Nat'l Memorial Park</i>
23d. LOCATION (City or Town) <i>Falls Church</i> (County) <i>VA</i> (State) <i>VA</i>		23e. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR <i>George Hawley Sons Inc. 5130 Wisconsin Ave. N.W.</i>		ADDRESS <i>Washington, D.C.</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
25a. DATE <i>OCT 31 1967</i>		25b. DATE <i>OCT 31 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5802 Wyngate Drive		d. STREET ADDRESS 5802 Wyngate Dr. 15-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Female W		First Helena	Middle MARIA
4. DATE OF DEATH Oct. 12, 1967		Lost	Month Doy Year
5. SEX Female W		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-9-1892		9. AGE (In years lost birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BAKER		14. MOTHER'S MAIDEN NAME RINGWALD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Husband W.T. Von Oettinger		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1952 Thymoma, malignant, recurrent and metastatic		INTERVAL BETWEEN ONSET AND DEATH 10 months	
DUE TO (b) _____ stating the underlying cause _____ lost. _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961, to Oct 12, 1967, that (I) (we) last saw the deceased alive on 10 Oct 1967, and that death occurred at 12A M, from causes and on the date stated above.			
22a. SIGNATURE Horace W. Bernton		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) HORACE W. BERNTON		22d. ADDRESS 4743 Bradley Blvd., Chevy Chase Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-13-67	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory
23d. LOCATION (City or Town) Suitland, Maryland		(County) (State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS	
25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retumed by the hospital or attending physician.

**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oiney</b>		c. LENGTH OF STAY IN 1b <b>II days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		d. STREET ADDRESS <b>9III2 Rosemont Drive</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Rachel Borrine Walker</b>		First	Middle	Lost	4. DATE OF DEATH <b>October 30 1967</b>	Month	Doy	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-86</b>	9. AGE (In years last birthday) <b>89 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Benton Hodland</b>				14. MOTHER'S MAIDEN NAME <b>Marian Hoy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Medical Records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 10/18/67 ↗ INTERVAL BETWEEN ONSET AND DEATH 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> ? (c) <b>Atherosclerotic Cardiovascular Dis</b> ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema, Asthma</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>3:50 P.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Milton D. Westberg</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Milton Westberg, M.D.</b>		22d. ADDRESS <b>431 N. Frederick Ave., Gaithersburg, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-2-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Oak</b>		23d. LOCATION (City or Town) <b>Gaithersburg</b>		(County) (State) <b>Montgomery Md</b>	
24. FUNERAL DIRECTOR <b>Joseph C. Gartner, Gaithersburg, Md.</b>		ADDRESS <b>11-2-67</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

other decisions still

involved in this question had

of course been made before

the Geneva

and the Geneva Conference before

the actual draft for the Geneva

Protocol was

the Geneva Conference before

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## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		15-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8507 Hempstead Ave.		d. STREET ADDRESS 8507 Hempstead Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Olive	Middle D.	Last Wallace.	4. DATE OF DEATH	Month October	Day 10	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1875	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Melvin Dunlap			14. MOTHER'S MAIDEN NAME Harriett Hair				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Daughter Mrs. Albert Ashton		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH Sev. mos. ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-25-1967 to 10-10-1967, that I last saw the deceased alive on 10-9-1967, and that death occurred at 15 M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Geo. A. Gray Jr.</u> M.D. 4740 Chevy Chase Dr., 10/10/67 PHYSICIAN'S NAME (Type) <u>Geo. A. GRAY, JR. M.D.</u> Chevy Chase, Md. 20015		ADDRESS (Street, city or town, state) DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-67		22c. NAME OF CEMETERY OR CREMATORIAL West Alexander Cem.		22d. LOCATION (City, town, or county) West Alexander, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 16 1967		24b. REGISTRAR'S SIGNATURE g Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14225

14230

## CERTIFICATE OF DEATH

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		d. STREET ADDRESS <i>3831 Newark St. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>TERESA</i>		Middle <i>BELLE</i>	Last <i>WARREN</i>	4. DATE OF DEATH <i>Oct 16 1967</i>	Month <i>Oct</i>	Day <i>16</i>	Year <i>1967</i>			
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-87</i>	9. AGE (In years last birthday) yrs. <i>80</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>				
13. FATHER'S NAME <i>Johan</i>		14. MOTHER'S MAIDEN NAME <i>Kondrup</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO.				
17. INFORMANT <i>Teressa</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic Cardio Vasc. Disease</i>		Acute Myocardial Infarction DUE TO <i>Obesity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Obesity</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <i>1964</i> to <i>10-16</i> , 1967, that (I) <del>we</del> last saw the deceased alive on <i>Oct 16 1967</i> , and that death occurred at <i>5:10 A.M.</i> from causes and on the date stated above.		22a. SIGNATURE <i>DeWitt E. DeLawter</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Oct 16 1967</i>				
22c. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLawter</i>		22d. ADDRESS <i>3848 Porter St NW. Wash D.C.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-19-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Cemetery</i>	23d. LOCATION (City or Town), (County), (State) <i>Arlington</i>		
24. FUNERAL DIRECTOR <i>Hanlon Funeral Home</i>		ADDRESS <i>Wasit. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 30 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14226

CERTIFICATE OF DEATH

14231

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Cedar Grove</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Cedar Grove</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 165, RFD # 1, Germantown</b>		d. STREET ADDRESS <b>Box 165, RFD # 1, Germantown</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Laura Jane Watkins</b>		First <b>Laura</b>	Middle <b>Jane</b>
Last <b>Watkins</b>		4. DATE OF DEATH <b>Oct. 3 1967</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	8. DATE OF BIRTH <b>July 22, 1893</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Cedar Grove, Md.</b>		9. AGE (In years lost birthday) <b>74 yrs.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William W. Soper</b>		14. MOTHER'S MAIDEN NAME <b>Catherine King</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Maynard D. Watkins, Sr. Item 2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>442 X</b> DUE TO <b>Advanced Arteriosclerotic Cardiovascular-Renal Disease with Severe Cerebral Arteriosclerotic Brain Deterioration.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years ?</b>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Terminal Pneumonitis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3 a. M.</b>
20f. (City or town) <b>3 a. M.</b>		(County) <b>3 a. M.</b>	(State) <b>3 a. M.</b>
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>January 1935</b> to <b>October 3, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>October 3, 1967</b> and that death occurred at <b>3 a. M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>October 4, 1967</b>	
22a. SIGNATURE <i>McKendree Boyer, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>9701 Church Street</b>
22c. PHYSICIAN'S NAME (Type) <b>McKendree Boyer, M.D.</b>		22d. ADDRESS <b>Damascus, Maryland.</b>	22e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Upper Seneca Baptist</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 6 1967</b>	25b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 3 days		c. LENGTH OF STAY IN lb <i>3 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>4607 Connecticut Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Clara Shenson</i>		First	Middle
4. DATE OF DEATH <i>October 25 1967</i>		Last	Month
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED WIDOWED <i>Never married</i>		8. DATE OF BIRTH DIVORCED <i>1/14/80</i>	
9. AGE (In years (last birthday) <i>87 yrs.</i>		10. IF UNDER 1 YEAR Months Dots Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Henry Clay Way</i>		14. MOTHER'S MAIDEN NAME <i>Catherine O'Keefe</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sister Mrs. Robert C. Lester</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction - recent and remote</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary arteriosclerosis with occlusion</i> DUE TO <i>lost.</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not-White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> to <i>Oct 25, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 25 1967</i> , and that death occurred at <i>3501 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Stewart Clapp M.D.</i>			
22b. DATE SIGNED <i>Oct 25 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>Stewart Clapp MD</i>		22d. ADDRESS <i>4740 Chevy Chase Dr.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-28-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>OCT 30 1967</i>			

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		d. STREET ADDRESS <b>14710 CARROLLTON RD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH STEWART</b>		First <b>ELIZABETH</b>	Middle <b>STEWART</b>
4. DATE OF DEATH Month <b>10</b>	Year <b>4 19 67</b>	5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>
7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-83</b>	9. AGE (In years last birthday) <b>84</b> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ROBERT S. STEWART</b>		14. MOTHER'S MAIDEN NAME <b>JANE MORAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>093-07-4939</b>	17. INFORMANT <b>MEDICAL RECORD DEPT.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage, Right Hemisphere; acute Bronchopneumonia, bilateral</b> DUE TO <b>9040</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemisphere; acute</b> DUE TO (c) <b>Bronchopneumonia, bilateral</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased fell at home &amp; struck head on floor</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 3000 pm <b>9-30 1967</b>		20d. INJURY OCCURRED While <b>2</b> Not While <b>1</b> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Rockville</b> (County) <b>Maryland</b> (State) <b>Maryland</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>BELDEN R. LEAP</b>		22. DATE SIGNED <b>Oct. 4, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. LEAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-9-67</b>	
23c. NAME OF CEMETERY OR CEMETORY <b>St. Raymond Cemetery</b>		23d. LOCATION (City or Town) <b>Bronx</b> (County) <b>New York</b> (State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS 25a. REC'D BY REGISTRAR DATE <b>OCT 9 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jagger</b>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14234

FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		d. STREET ADDRESS <b>2019 EDGEWATER PARKWAY</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		151	
3. NAME OF DECEASED (Type or print)	First <b>ARTHUR</b>	Middle <b>JOSEPH</b>	4. DATE OF DEATH Month <b>OCTOBER 12 1967</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 20, 1920</b>
9. AGE (In years last birthday) <b>47 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL ENGINEER</b>	11. BIRTHPLACE (State or foreign country) <b>BROOKLYN, NEW YORK</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ISAAC WEINBERGER</b>	14. MOTHER'S MAIDEN NAME <b>ROSE WEINBERGER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. <b>033-16-0243</b>	17. INFORMANT <b>WIFE - MRS. SOPHIA WEINBERGER</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocarditis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>Oct. 12, 1967</b>	
ACTUAL SIGNATURE <i>Belden R. Read</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>BELDEN R. READ M.D. Intention</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Anatomical</b>		23b. DATE THEREOF <b>10-12-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>GEORGETOWN UNIVERSITY</b>
24. FUNERAL DIRECTOR <b>DONALD M. STEIN</b>		ADDRESS <b>232 CARROLL ST. N.W. WASH. D.C.</b>	25a. REC'D BY REGISTRAR DATE <b>OCT 16 1967</b>
HEBREW MEMORIAL FUNERAL HOME		25b. REGISTRAR'S SIGNATURE <i>People's Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14230

CERTIFICATE OF DEATH

14235

1. PLACE OF DEATH a. COUNTY	MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	BETHESDA 23 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	9527-Old GEORGETOWN R.R.D.		d. STREET ADDRESS 9527-Old GEORGETOWN RD.		
3. NAME OF DECEASED (Type or print)	First Bertha	Middle I.	Last WenK	4. DATE OF DEATH Oct. 25, 1967	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED WIOOWEO	8. DATE OF BIRTH 8-19-1880	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME THOMAS RICHARDS	14. MOTHER'S MARRIED NAME MIMIE GIBBONS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Myrtle Carlin	Address 13.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 442X DUE TO (b) <i>Cerebral thrombosis</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c) <i>Cardio-Vascular Renal Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that (I) (this hospital) attended the deceased from 1953, 19, to Oct. 25, 1967, that (I) (we) last saw the deceased alive on Oct 25 1967, and that death occurred at 8 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Harold Heiges	22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Harold Heiges	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 5415 Corn Ave NW DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-28-67	23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM. BLADENSBURG, MD.	23d. LOCATION (City, town or county) Bladensburg, MD.	(State)	
24. FUNERAL DIRECTOR HANLON FUNERAL HOME -	ADDRESS Wash. D.C.	25a. REC'D BY REGISTRAR OCT 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20M 1/65					

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 16 & 22b Film #G395 11/21/67 ph

14232

14236

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5620 Oakmont Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles Edward Kornel</i>		First <i>Charles</i>	Middle <i>Edward</i>
4. DATE OF DEATH <i>October 28 1967</i>		Lost <i>None</i>	Month Doy Year 19 67
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>April 17-1884</i>		9. AGE (In years at time of death) <i>83</i>	
10. USUAL OCCUPATION (Give kind of work done during past 6 working life, even if retired) <i>Retired -</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Merline Leinweber Wisconsin</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frederick Kornel</i>	
14. MOTHER'S MAIDEN NAME <i>Pauline A. Jacob</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>390-05-5711</i>		17. INFORMANT <i>Marked Briggs - 8815 Falls Rd - Bethesda</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Urinary</i> lost.		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
(b) DUE TO <i>Carcinoma of prostate</i>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinomatosis</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>February 19 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Rockville</i>		(County) (State) <i>Md. MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>February 19 1967</i> to <i>Oct 28 1967</i> that (I) (we) last saw the deceased alive on <i>Oct 27 1967</i> , and that death occurred at <i>1 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>Oct. 28, 1967</i>	
22c. SIGNATURE <i>Stephen C. Cromwell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>Rockville, Md.</i>		23d. LOCATION (City or Town) <i>Rockville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-1-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	
25b. REC'D BY REGISTRAR <i>NOV 1 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 18-21 Film 395  
11-20-67 a.m. Item #9 Film #G393 10/17/67 ph  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14237

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> D.O.A.		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>	
d. STREET ADDRESS <b>18635 Brook Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		First <b>Delores</b>	Middle <b>Williams</b>
4. DATE OF DEATH <b>October 8 1967</b>	Month Day Year	5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>Oct. 18, 1934</b>	10. AGE (In years 32 lost birthday) <b>33</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Williams</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Dorsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ruby Johnson, Sister 18635 Brook Rd Brinklow</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure due to</b> DUE TO 871.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>synergistic action of alcohol and</b> DUE TO stating the underlying cause (c) <b>barbiturates</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased ingested alcohol and barbiturates to excess</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>1:00 pm 10-8 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. (City or town) <b>Brinklow</b>		(County) <b>Montg.</b>	
(State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belinda R. Keap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>Belinda R. Keap M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>Oct. 8, 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/14/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Brooke Grove</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden Rockville, Md.</b>		23d. LOCATION (City or Town) <b>Haytontown, Md.</b>	
ADDRESS		25a. REC'D. BY REGISTRAR <b>Oct 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Belinda R. Keap</b>
DATE		151	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14233

14238

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.	
3. NAME OF DECEASED First ALBERT Middle WINER		d. STREET ADDRESS 2101 Fairland Rd.	
3. NAME OF DECEASED First ALBERT Middle WINER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 08/15/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer		9. AGE (In years lost birthday) 77 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) Russia	
13. FATHER'S NAME Eliezer Winer		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 577-09-2646	
17. INFORMANT Henry Winer - 10120 Brock Dr. S.S.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inversible Shock</u> DUE TO <u>4200</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute Pulmonary Edema</u> DUE TO <u>arterio Sclerotic Heart Disease</u>		3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>uremia</u>		4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1962</u> , to <u>Oct 31, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 31 1967</u> , and that death occurred at <u>2:35 PM</u> , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22. SIGNATURE <u>Raymond T. Benack</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/31/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>		22d. ADDRESS <u>4115 Colie DR. Wheaton MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-2-67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>King David Memorial Garden</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky and sons</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>	
25a. REC'D BY REGISTRAR <u>3501-144814</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. DATE <u>NOV 3 1967</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14234

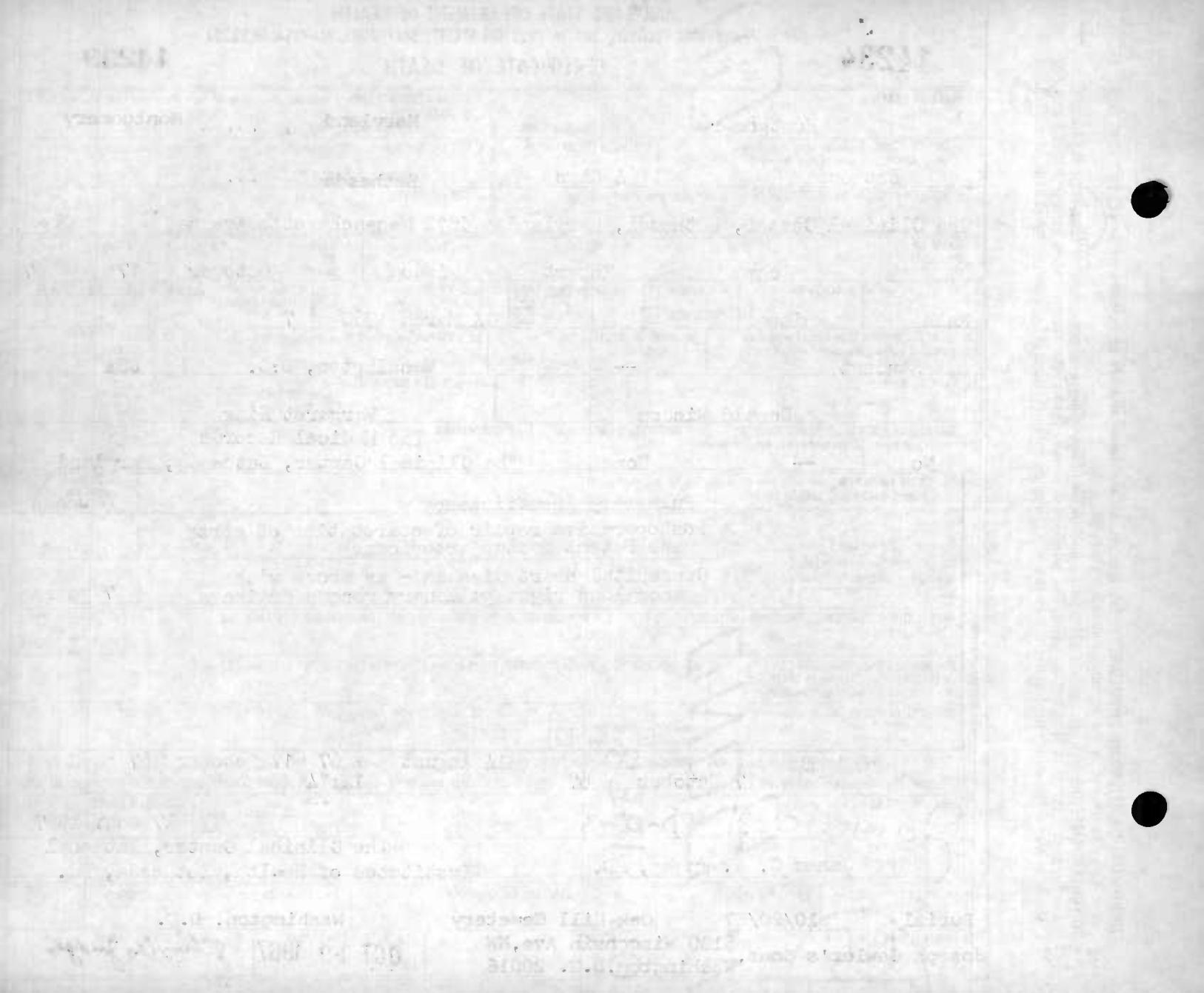
CERTIFICATE OF DEATH

14239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland, D.C. b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 64 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First John Middle Robert Lost		4. DATE OF DEATH Month October Doy 17 Year 1967				
5. SEX Male White		6. COLOR OR RACE 7. MARRIED NEVER MARRIED <input type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		8. DATE OF BIRTH 14 March 1960				
10b. KIND OF BUSINESS OR INDUSTRY --		9. AGE (In years lost birthday) 7 yrs.				
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Donald Wisdom		14. MOTHER'S MAIDEN NAME Margaret King				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None				
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545 Pulmonary insufficiency DUE TO Postoperative repair of coarctation of aorta and Patent ductus arteriosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Congenital heart disease - as above with anomalous right pulmonary venous drainage DUE TO (c) 7 years						
INTERVAL BETWEEN ONSET AND DEATH 6 weeks						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 14 August 1967, to 17 October 1967, that <input type="checkbox"/> (we) last saw the deceased alive on 17 October 1967, and that death occurred at 12:14 PM, from causes and on the date stated above.						
22a. SIGNATURE James C. A. Fuchs		22b. DATE SIGNED 17 Oct. 1967				
22c. PHYSICIAN'S NAME (Type) James C. A. Fuchs, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, ADDRESS Washington, D.C. 20016		25a. REC'D BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14235

CERTIFICATE OF DEATH

14230

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

3 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Oakhaven Convalescent Home

3. NAME OF  
DECEASED  
(Type or print)

First  
Frances

Middle  
S.

Last  
Wise

4. DATE  
OF  
DEATH  
10-29 -

Month  
Year  
1967

5. SEX

W

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

Sept 28, 1888

9. AGE (In years  
last birthday)

87  
yrs.

10. IF UNDERR 1 YEAR

Months  
0

11. IF UNDER 24 HRS.

Days  
0

Hours  
0

Min.  
0

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Austria

12. CITIZEN OF WHAT  
COUNTRY?

U.S.

13. FATHER'S NAME

Frank Shikula

14. MOTHER'S MAIDEN NAME

Mary (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-54-7448

17. INFORMANT

Address

Silver Spring Md  
Frances Hartnett 9907 Cottrell Terrace

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

332X

OUT TO

Conditions, If any, which  
gave rise to Immediate  
cause (a), stating the  
underlying cause last.

(b)

DU TO

(c)

Cardiac thrombosis affecting Rami

Old age + Arteriosclerosis, general

INTERVAL BETWEEN  
ONSET AND DEATH

3 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

2. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. 19

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/29/67, 1967 to 10/29/67, 1967 that (I) (we) last  
saw the deceased alive on 10/26/67, 1967, and that death occurred at 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

John H. Holton

22b. DATE SIGNED

Oct. 29, 1967

22c. PHYSICIAN'S  
NAME (Type)

John H. Holton

M.D. ATTENDING  
PHYS.

M.D. DIRECTOR  STAFF  
PHYS.

22d. ADDRESS

831 University Blvd. E. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)

Burial Nov. 2, 1967

Gate of Heaven Cemetery

Silver Spring Md

Funeral Director John B. Thomas

8434 Georgia Avenue

Reg'd by Registrar Nov 3, 1967

Warner E. Pumphrey, Inc.

Silver Spring, Md.

Reg'd by Registrar Nov 3, 1967



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

14236

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>S. Carolina</b> b. COUNTY <b>Charleston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>9 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Georgetown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>2501 Redwood Street</b>			
3. NAME OF DECEASED (Type or print) <b>Lois Munn</b>				4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 September 1910</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <b>Savannah, Georgia</b>		12. IF UNDER 24 HRS. 13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Henry C. Munn</b>				14. MOTHER'S MAIDEN NAME <b>Louise BARBOUR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>250 76 0205</b>			
17. INFORMANT <b>Ivey F. Munn</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Stenosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>410X</b> (b) <b>Rheumatic heart disease</b> DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that (I) (this hospital) attended the deceased from <b>3 October</b> , 19 <b>67</b> to <b>12 October</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12 October</b> , 19 <b>67</b> , and that death occurred at <b>2 PM</b> , from causes and on the date stated above.				22. DATE SIGNED <b>12 October 1967</b>			
22a. SIGNATURE <b>J. R. Fletcher</b>				22b. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-15-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Charing Cross Gem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Georgetown City S.C.</b>	
24. FUNERAL DIRECTOR <b>John Pumphrey 7557 Wisconsin Ave., Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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14237 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH  
14242

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
		<b>Baby girl</b>		<b>Worth</b>	<b>October</b>	<b>26</b>	<b>1967</b>	

5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 26</b>	67	9. AGE (In years last birthday) - yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME <b>Robert Lee Worth</b>	14. MOTHER'S MAIDEN NAME <b>Mary Julia Perry</b>
--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<b>no</b>		<b>Mary Perry Worth-2402 Elvans St. SE</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b>		<b>prematurity</b>
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from <b>10-26</b> , 19 <b>67</b> , to <b>10-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-26</b> 19 <b>67</b> , and that death occurred at <b>1055</b> M, from the causes and on the date stated above.	22a. SIGNATURE <i>Melvin W. Sandmeyer</i>	22b. DATE SIGNED <b>10-27-67</b>
---	--	-------------------------------------

22c. PHYSICIAN'S NAME (Type) <b>Melvin W. Sandmeyer, MD</b>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>1106 Spring St. Silver Spring, Md.</b>
--	---	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/30/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>	23d. LOCATION (City, town or county) <b>Silver Spring, Md.</b>	(State)
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>	25a. ADDRESS <b>1591 Rockville Pike Rockville, Maryland</b>	25b. REC'D BY REGISTRAR <b>Charles Young</b>	DATE <b>OCT 31 1967</b>	(State)

1600

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14238

14243

## CERTIFICATE OF DEATH

Item #4 - Sect. C 11/1967-503.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>@ 4 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>Burtons Lane</b>	
3. NAME OF DECEASED (Type or print) <b>B aby Girl Yerger</b>		First <b>B aby</b>	Middle <b>Yerger</b>
4. DATE OF DEATH <b>Oct 22 1967</b>	Month <b>Oct</b>	Doy <b>22</b>	Year <b>19 67</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Mont. Cty, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph L. Yerger</b>		14. MOTHER'S MAIDEN NAME <b>Barbara L. Luticia Henderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>prematurity (immaturity)</b> DUE TO <b>776X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>07</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 32 - 10am 1967</b> , to <b>Oct. 22 - 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 22 1967</b> , and that death occurred at <b>2:30PM</b> . Main causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <b>Chester L. Wagstaff</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Chester L. Wagstaff, M.D.</b>		22b. DATE SIGNED <b>Oct. 23, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Oct. 23, 67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Glenview Chapel</b>
24. FUNERAL DIRECTOR <b>Hunter Laboratories</b>		ADDRESS <i>7-294-1-</i>	23d. LOCATION (City or Town) <b>Montgomery Gen. Hospital</b> (County) (State)
		25a. REC'D BY REGISTRAR <b>Charles J. Yerger</b>	25b. REGISTRAR'S SIGNATURE
		DATE <b>OCT 30 1967</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		14238		14238			
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery		Kensington		8 days.		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STREET ADDRESS		b. COUNTY	
Kensington		8 days.		Silver Spring		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		151	
Kensington Garden Sanitarium		90		10713 Douglas Ave.			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Year
Marija		J.	Zakis		October	6	1967
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
F		W			12-17-1892	74 yrs.	9 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housekeeper		Own Home		Latvia		Latvia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address 10713 Douglas Ave. Silver Spring, Md.			
Paul Balins		Unk. Lote					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No		579-42-8118A		Mrs. Olga Zarins		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Hypertension; arteriosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 3mos.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year Hour o.m. p.m.		19					
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1967, to <u>Oct. 5</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct. 5</u> , 1967, and that death occurred at <u>12:25</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>Philip H. Warner</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-6-67	
22c. PHYSICIAN'S NAME (Type)		Philip H. Warner		22d. ADDRESS 7702 Connecticut Ave., Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
Burial		Oct. 9, 1967		Kock Creek Cemetery		Washington D. C.	
24. FUNERAL DIRECTOR		8439 ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John B. Thomas		8439 Georgia Ave.					
Warner E. Pumphrey, Inc.		Silver Spring, Md.		DATE OCT 9 1967		jCharles Judge	



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10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14245

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 11 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 6725 Eastern Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San + Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Irving	Middle Franklin	Last Zimmerman
4. DATE OF DEATH Month October	Month 23	Day 1967	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 3-15-08	9. AGE (In years lost birthday) 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Harmer's Grocery	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Joseph Zimmerman		14. MOTHER'S MAIDEN NAME Florence McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO. 577-03-4367	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>Old myocardial infarction</i> DUE TO <i>Debileus Mullitus</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years 3 months 22 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Open Enteroscopy</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/91, 1966 to 10/23, 1967, that (I) (we) last saw the deceased alive on 10/23/1967, and that death occurred at 10 AM, from causes and on the date stated above.		22b. DATE SIGNED 10/23/67	
22c. PHYSICIAN'S NAME (Type) Howard T. Morse, M.D.		22d. ADDRESS 3030 Carroll Ave, Takoma Park, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 26, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery, St. Louis, Mo.		23d. LOCATION (City or Town) Frederick (County) (State) Md	
24. FUNERAL DIRECTOR Arthur Wallers Washington, D.C.		25a. REG'D BY REGISTRAR DATE OCT 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

